

PRINTED: 12/07/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2017	
NAME OF PROVIDER OR SUPPLIER SEVIERVILLE HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 415 CATLETT RD SEVIERVILLE, TN 37862		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual Licensure survey was conducted on 11/28/17 through 11/30/17 at Sevierville Health and Rehabilitation Center. No health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 1